STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175517	A. BUILDING _____ B. WING _____	C 06/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET LIFE AT BROOKDALE PLACE	12000 LAMAR OVERLAND PARK, KS 66209

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation # 75797 A revised copy of the deficiencies was sent to the facility on 6/26/14.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 96 residents. The sample included 3 residents reviewed for falls. Based on observation, interview, and record review, the facility failed to provide adequate supervision and effective interventions to prevent falls for 1 of 3 residents reviewed for accidents (#3). Findings included: - Diagnoses listed on the Physicians Order Sheet (POS) of 5/20/14 for resident #3 of left proximal humerus fracture, (a broken bone in the arm), dementia, (progressive mental disorder characterized by failing memory, confusion), brain mass (an abnormal growth of tissue in the brain), hypertension, (elevated blood pressure), depression (abnormal emotional state	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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characterized by exaggerated feelings of sadness, worthlessness and emptiness), diabetes, (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), insomnia, (inability to sleep), hypothyroidism, (condition characterized by decreased activity of the thyroid gland), mood disorder (category of mental health problems,feelings of sadness, helplessness, guilt, wanting to die were more intense and persistent than what may normally be felt from time to time) and a history of falls.

The admission Minimum Data Set (MDS) dated 5/27/14 listed a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS identified the resident required extensive assistance of 2 plus persons for bed mobility, transfers, locomotion on unit, dressing, and toilet use, and limited assistance of one staff for locomotion off the unit, eating, and personal hygiene. The resident did not walk in the room or the corridor, did not have a trial toileting program, and was frequently incontinent of bowel and bladder. The resident had a fall in the last month prior to admission/entry or reentry, had a fall in the last 2-6 months prior to admission entry or reentry, and sustained a fracture related to a fall in the 6 months prior to admission/entry or reentry. The resident was not steady, only able to stabilize with staff assistance moving from a seated to standing position, moving on and off the toilet and with surface to surface transfers.

The Care Area Assessment (CAA) dated 6/2/14 for cognition listed the resident had a diagnosis of dementia and both long/short term memory loss, did have some impairment in his/her decision

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making process, but could make basic needs known, answered questions but had a little lag in response, staff to give him/her time to communicate, currently received galantiamine and namenda, medications for dementia. The resident was at risk for declines physically and cognitively due to the progressive nature of the disease and was referred to speech therapy (ST).

The CAA for incontinence dated 6/2/14 listed functional incontinence of the bladder,and the resident required extensive assistance of staff to complete toileting, and had a fractured humerus.

The CAA for falls dated 6/2/14 listed the resident was at risk for falls due to a history of falls and a fall risk assessment score of 20. Factors for fall risk included: a decline in function and mobility, decreased safety awareness due to diagnosis of dementia, use of anti-psychotic and antidepressant medications, and immoblized humerus fracture. Staff kept his/her bed in the low position and he/she did have a personal alarm to alert staff to unassisted transfers. Staff referred him/her to physical, and occupational therapies for rehabilitation.

The interim Plan of Care (POC) dated 5/20/14 for falls listed to maintain safety from falls and or manage falls, introduced to call light, water pitcher, and roommate, move furniture as needed to make room for safe mobility. Personal alarms as needed, observe for unsteady gait, dizziness, and intervene as needed,keep adaptive devices within reach, verbally remind the resident not to ambulate alone, positioning devices as needed, low bed, fall mat at bedside, wheelchair for locomotion, assist with transfers and ambulation as needed, observe for any unsafe actions and

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intervene, and gripper socks or nonskid sole shoes.

A nurse's note (NN) dated 5/23/14 at 10:30 A.M.. revealed the nurse was called to the room regarding resident's fall. Staff found the resident on the floor lying on his/her back the facility transferred the resident to the hospital at 10:40 A.M. by emergency medical technicians (EMT) with cervical collar on, (a device used to to prevent or minimize motion in the cervical spine).

A NN dated 5/23/14 not timed, listed the resident received skilled nursing services for left hummers fracture, had a bruise on his/her left shoulder, complained of pain on the left shoulder, and headache after a fall this morning.

Review of the Hospital Instructions Emergency Room form dated 5/23/14 at 3:39 P.M. listed the resident sustained a compression fracture of a vertebra (bone) in the thoracic spine, (the area of the vertebral column commonly referred to as the mid and upper back). The form further listed the resident had a new brain bleed that was inoperable. Hospital staff discussed this information with the attending physician at the facility, and he/she would initiate hospice care for the resident.

Review of the facility reported incident dated 5/27/14 revealed when staff toileted the resident on 5/23/14, staff shut the door and the cognitively impaired resident with a high fall risk, and history of falls was left unattended in the bathroom. A loud noise was heard from the bathroom a few minutes later, and on entry to the bathroom staff observed the resident lying on the bathroom floor.

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The care plan revision dated 5/23/14 at 10:00 A.M. listed the resident fell in the bathroom. Interventions included: medications reviewed, laboratory results reviewed, continue previous fall interventions (floor mats at bedside, personal alarm on while in wheelchair and bed, low bed) and the resident was not to be left alone in the bathroom.

The care plan for falls dated 6/8/14 listed the resident was at high risk for falls, due to a recent fall and fall risk assessment score of 20. Will have no fall with injury during the next review period. Interventions included: falling star program, star outside the door to alert staff of increased risk for falls, a personal alarm in the bed and chair, mats on the floor by the bed, a low bed placed in the lowest position, non skid shoes, star by my name on the nurses jot sheet so they were aware that the resident was a high fall risk, bed in the lowest position, if a fall occurs I will be further assessed to determine the need for other interventions such as mats at the bedside, personal alarms (PA),(both already on the care plan) bed against the wall, gait belt for transfers, currently on therapy caseload to improve strength and endurance and not to leave the resident alone in the bathroom.

On 6/19/14 at 1:15 PM the resident sat in his/her room in the wheelchair (w/c) with the PA attached to the resident. The call light was not within reach.

On 6/19/14 at 5:05 P.M. the resident sat in his/her room in the w/c. On the bed rested a PA, not connected to the resident or the wheelchair, and the call light was not in reach.

Interview on 6/19/14 at 5:06 P.M. with direct care

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staff O stated he/she did all cares for the resident. He/she had floor mats when in bed, and a PA in the bed, but not in the chair, he/she did not try to get up when in the chair. The care plan identified the need for the PA when in the bed or the chair.

Review of the jot sheet carried by direct care staff O listed interventions of: the low bed, PA, floor mat, and not left alone on the toilet.

Interview on 6/19/14 at 5:20 P.M. with Administrative Nursing Staff D stated he/she was aware of the observation of the resident without a PA connected to the w/c, the jot sheet listed the PA and staff knew this was to connect the PA on the chair or bed if that was where the resident currently was.

Interview with the resident on 6/23/14 at 11:36 A.M. the resident sat in front of the nurses station in a w/c with the PA attached. He/she stated he/she needed to find his/her clothes to leave.

Interview with licensed nursing staff H on 6/23/14 at 1:30 P.M. the resident required extensive assistance, he/she was incontinent of bowel and bladder, had a bed and chair alarm, when he/she was in an activity or awake he/she was kept by the nurses station so all eyes were on him/her if he/she tried to stand up, which he/she did but not often. When he/she said he/she wanted to go home was the danger time when he/she would try to stand up.

Interview with direct care staff P on 6/23/14 at 1:35 P.M. revealed the resident required set up with all cares, staff got him/her up in the morning and took him/her to the toilet. The resident had a

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chair and bed alarm that were on at all times, and floor mats went in place when staff laid him/her down. When staff toilet him/her staff place the resident on the toilet and close the door to provide privacy, but keep it cracked and watched, when he/she started using the toilet paper direct care staff P went in to help. The resident would stand up and tried to pull clothes up if staff did not get in to assist him/her quick. The resident sat at the nurses station when he/she was up in the chair so staff could watch him/her.

Review of the facility policy for fall prevention dated revised 3/1/11 listed under the initial fall risk assessment if a resident scored above 10 he/she was at high risk for falls and would be placed on the Falling Star/Leaf Program. The care plan would reflect he/she was at high risk for falls and identify approaches that were implemented. A distinction would be made to alert all disciplines by placing a leaf/star on the resident's name plate outside his/her door to alert staff to observe safety precautions. Other possible staff interventions were to stay with the resident while on the commode or toilet if the resident permits.

The facility failed to provide adequate supervision for this cognitively impaired, dependent resident with a history of falls that fell and received a compression fracture of the vertebra in the thoracic spine, and received a brain bleed when staff left him/her unattended on the toilet. The facility failed to provide interventions as planned for the prevention of additional falls.